Psychological problems in the perinatal period

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Overview

- Psychological stages of pregnancy
- Perinatal mental health disorders
  - Traumatic birth
- Signs and symptoms of perinatal mental health problems
- Treatments
- Current service / referral pathways

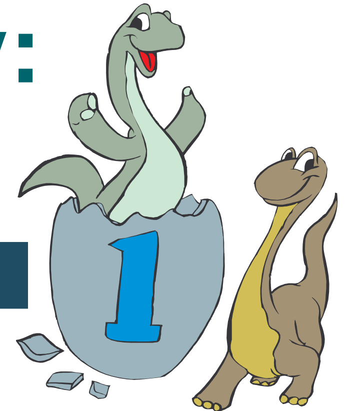
Psychological Stages of Normal Pregnancy

- Pre-conception:
  - Beliefs relating to self as mother and partner as father
- First stage, realisation to fetal movement:
  - Ambivalence – task is acceptance
- Second stage, fetal movement to discomfort:
  - Peace – task is attachment
- Third stage, physical discomfort
  - Anxiety – task is preparation

High-Risk Pregnancy

- Generally women may struggle with each stage of pregnancy – ambivalence is lengthened, acceptance is impaired and preparation may not occur at all
- The stages of pregnancy are consecutive; a woman cannot accomplish attachment if acceptance does not occur
- A heterogeneous group – affected by when high risk was identified, nature of treatment, individual characteristics of the woman

Stages of High-Risk Pregnancy: Stage 1 (acceptance)



- If high-risk diagnosis is made early, acceptance may be more difficult. Women simultaneously must accept the pregnancy but also face the possibility of loss.
- Ambivalence may be lengthened, and may persist throughout the pregnancy or until the perceived threat has resolved.

- **Potential issues:** loss (abortion, miscarriage); personal history (recurrent miscarriage, infertility treatment); tokophobia; denial of pregnancy (from emotional to psychotic); reduced/absent maternal medication

Stages of High-Risk Pregnancy: Stage 2 (attachment)

- Feelings of attachment remain undeveloped, for fear of disappointment
- Health-protective & promoting behaviours are reduced or absent
- Separation issues are emphasised (e.g. medication/intervention)
- Resentment may be compounded and confused by guilt and responsibility

- **Potential issues:** tokophobia; personal history (abuse, maternal conflict); maternal and fetal interventions; unwanted pregnancy; poor compliance

Stages of High-Risk Pregnancy: Stage 3 (preparation)

- Preparatory behaviours are reduced or absent
- Normal dependency is increased and adoption of a ‘sick role’ is common – may lead to learned helplessness, depression and decreased compliance (when a more negative outcome is expected)

- **Potential issues:** loss (stillbirth); pain, discomfort; fear of pain, death; phobias (needles, hospitals, labour); physical complications (placenta praevia, multiple birth); mode of delivery (vaginal, instrumental, operative)

Postnatal period

- Bonding with the infant may not occur
- Resentment may be high, particularly if the birth was traumatic, which may lead to rejection
- Women with very high expectations are likely to be disappointed; this is a risk factor for PN depression

- **Potential issues:** postnatal depression; puerperal psychosis; postnatal post-traumatic stress disorder; loss (infant death); prematurity; pain (perineal, breast); physical complications (haemorrhage, etc); poor bonding

Perinatal Mental Health Disorders

- Antenatal mental health
- Postnatal mental health
- Loss
- Pain

Antenatal Mental Health Problems

- Antenatal anxiety
- Antenatal depression
- Pre-existing mental health problems such as schizophrenia, bipolar disorder, OCD
- New mental health problems with an onset during pregnancy

Phobias

- Tokophobia: fear of childbirth
- Haemophobia: fear of blood
- Iatrophobia: fear of doctors
- Aichmophobia: fear of needles
- Emetophobia: fear of vomiting
- Thanatophobia: fear of death
- Fear of own changing body

Denial of Pregnancy: Emotional

- The woman will acknowledge she is pregnant but not change diet, wardrobe or future plans
- Common in bereaved mothers
- Working through unresolved grief may help mothers bond with their babies and allow a separate identification from the lost child
- Also seen in drug-addicted mothers who feel guilty about potential consequences

‘Rachel’, aged 26

- Previous stillbirth, girl at 36 weeks, normal delivery, baby died just before birth
- Pregnant for the second time, requested input
- Felt detached from the pregnancy, did not buy anything, or prepare in any way
- Very anxious that she felt nothing for the baby
- Husband also traumatised by the stillbirth and couldn’t discuss the current pregnancy without becoming angry and violent
- Extremely anxious about going to 36 weeks – asking for a caesarean section at 34 weeks

Denial of Pregnancy: Psychotic

- The woman will suppress awareness of her pregnancy throughout and will typically gain no/little weight, attribute bleeding and sickness to other causes, may dissociate during labour and will misinterpret labour signs – e.g. ruptured membranes as urination
- Risks: young age; passivity; family and/or cultural taboos; sexual abuse history; low IQ or lack of knowledge; stress such as separation from father of child; social isolation; breech presentation; irregular menses

Denial of Pregnancy: Psychotic (2)

- Consequences: failure to receive antenatal care; inadequate nutrition; failure to avoid risks to pregnancy; unassisted delivery; neonaticide (active or passive); loss of custody of the child
- Psychotic denial of pregnancy is rare, but is most common in women with pre-existing psychotic disorders, appears to be intensified by stress, and may be a defence against overwhelming feelings of loss in the past or anticipated in the future

Abuse History

- Sexual abuse memories may be triggered by pregnancy, childbirth or intervention
- Some experience flashbacks analogous to forced intercourse or feelings that their bodies are out of control
- Labour can be experienced as intrusive, humiliating or frightening
- Can have the effect of slowing labour, due to tensing of muscles and a psychological inability to ‘let go’, resulting in failure to progress and potential caesarean section
- Domestic abuse rises as much as eightfold in pregnancy

High-Risk Pregnancy

- Placenta praevia
- Multiple birth
- (Pre)-eclampsia
- Antepartum haemorrhage
- Hyperemesis gravidarum

Interventions complicated by pregnancy

- May need to stop/reduce medication or other forms of treatment when pregnant
- Treatment may need to be delayed; e.g. chemotherapy, HIV treatment

‘Holly’, aged 31

- Diagnosis of reflexive sympathetic dystrophy, characterised by neuropathic pain
- Taking Gabapentin to manage neuropathic pain, which cannot be taken during pregnancy
- Holly decided to cease her medication in order to try for a baby, resulting in excruciating pain
- Signed off from work
- Husband keen for a family but guilty that she was experiencing pain and asked her to restart medication – Holly refused
- Significant marital strain, despite supportive relationship

Baby Blues

- Experienced by up to 80% of women around days 3-10 postnatally
- Increased tearfulness, fatigue, emotional lability, irritability, feelings of unreality, sleep problems
- Resolves spontaneously in the vast majority
- Unknown whether biological, obstetric or psychosocial cause

Postnatal Depression

- Approximately 13% of the postnatal population develop PND
- Highest incidence around 8 weeks postnatal, with the majority resolving spontaneously by 6 months, but may last up to 1 year
- Serious long-term effects on the child including behavioural, social, developmental and emotional deficits

Postnatal Depression (2)

- Predictive factors include:
  - Specific perinatal factors (eg mode of delivery)
  - Individual factors (eg psychiatric history)
  - Socio-economic factors (eg household income)
  - Postnatal factors (eg emotional support)
  - Cognitive factors (eg locus of control)

Puerperal Psychosis

- Rare – approximately 1 per 1000 births
- Women experience a psychotic break and most are hospitalised (preferably in a mother-baby unit)
- Risk of recurrence is high after subsequent pregnancy – around 2/3
- Generally, women are not at increased risk of psychosis at any other time

Loss

- Abortion or termination of pregnancy
  - Unplanned/unwanted pregnancy
  - Fetal anomaly
  - Must be considered within the woman's social, religious and personal context
  - Nearly always guilt and self-blame, sometimes self-punishment
  - Feelings re another child may be complex

‘Louise’, aged 38

- Chose to have a TOP for fetal anomaly
- Strong feelings of guilt and self-blame, and many symptoms of PTSD
- Relevant history: a previous TOP resulting from an extra-marital affair – husband unaware
- Planned pregnancy, a healthy baby girl
- Symptoms of PTSD remained unresolved postnatally
- Re-presented for therapy 18 months later

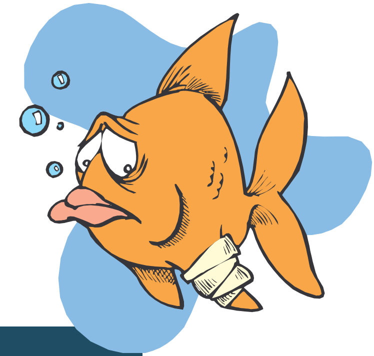
Loss (2)

- Miscarriage
  - Overwhelming grief, often not understood by those around them, particularly if early in gestation
  - Often minimised by others
  - Validation and normalisation of the woman’s experience is crucial

Loss (3)

- Stillbirth
  - Unexpected, and always shocking
  - Rituals are important, but so is the woman's right to choose not to experience these - seeing/holding/touching the baby; footprints; photographs; hair
  - Tends to result in a belief that the world is no longer a safe place

Pain



- Abdominal pain may become distressing during the third trimester
- Labour pain is feared by most women
- Perineal pain may be present postnatally and may be difficult to treat
- Breastfeeding may be very painful

Traumatic birth: PTSD

- Recognised officially in 1994, DSM-IV
- Fear of death or breach of bodily integrity for self or another
- Characterised by avoidance, reliving and hyper-arousal
- Diagnosable in around 2% of postnatal population, with trauma symptoms present in around 33%
- May present later (i.e. in a subsequent pregnancy)

Symptoms

- Avoidance: reminders of the birth such as hospitals, pregnant women, babies; emotional numbing / distancing of self
- Hyperarousal: poor sleep, mood, memory, concentration, appetite; high startle response; anger outbursts; tearful
- Reliving: dreams, nightmares, flashbacks, intrusive thoughts / images

Impact

- Some women avoid / resent their baby
- Some cling to their baby
- The situation is worse when physical symptoms persist
- Objectively traumatic birth appears to be most predictive (but not exclusively)
- Daily functioning is highly impaired
- Relationships with others are damaged

‘Jane’, aged 28

- First pregnancy/birth unremarkable
- History of gynaecological problems – lost an estimated 4½ pints of blood, ambulance broke down, complete loss of control
- Antenatal PTSD
- Pregnant for the second time – convinced she would die through massive haemorrhage

Physiotherapy Involvement

- Always ask re symptoms (reliving, avoidance, hyperarousal)
- Be aware of comorbidity with depression
- Find out about local services
- Consider joint early identification (physio / psychology)
- Postnatal classes

Differential Diagnosis: PTSD / PND

- The person repeatedly relives the event (1 symptom)
  - Marked mental distress in reaction to internal or external cues that symbolize or resemble the event

Within 2 weeks, the patient has had 5 or more of the following (a definite change from usual). Must include depressed mood or decreased interest / pleasure:

For most of nearly every day, the patient reports depressed mood or appears depressed to others.

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  - Intrusive, distressing recollections - thoughts, images
  - Repeated, distressing dreams.
  - Flashbacks, hallucinations or illusions cause the person to act or feel as if the event were recurring
  - Physiological reactivity - such as rapid heart beat, elevated blood pressure in response to these cues.

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  - Feels life will be brief or unfulfilled (lack of marriage, job, children).
  - Tries to avoid thoughts, feelings or conversations concerned with the event
  - Tries to avoid activities, people or places that recall the event

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  - Insomnia (initial or interval)

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  - Increased startle response

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  - Insomnia (initial or interval)
  - Poor concentration
  - Increased startle response
  - Irritability
  - Hypervigilance

- Nearly every day the patient sleeps excessively or not enough, there is fatigue or loss of energy.
- Noted by the patient or by others, nearly every day the patient is indecisive or has trouble thinking or concentrating.
- Nearly every day others can see that the patient's activity is agitated or retarded.
- A marked loss / gain of weight) or appetite is markedly decreased or increased nearly every day.
- Nearly every day the patient feels worthless or inappropriately guilty. These feelings are not just about being sick; they may be delusional.

Differential Diagnosis (PTSD / PND)

- At the heart of PTSD lie involuntary re-living experiences (intrusive thoughts, nightmares, flashbacks) whereas postnatal depression is more characterised by ruminative thoughts
- High degree of comorbidity (~50%)
- Difficult to diagnose depression, particularly as nearly all symptoms are shared by PTSD

Signs and Symptoms of Mental Health Disorders

- Consistently missing appointments or arriving late
- Reluctant to discuss the birth in any detail OR
- Overly concerned with planning the birth
- Any mention of ‘flashbacks’ or feeling that they are re-experiencing a prior birth
- Previous history of any mental health problem, particularly in the perinatal period
- Anxiety is out of proportion to events in the pregnancy / birth
- Regularly does not maintain eye contact
- Regularly allows another to speak for her
- Previous history of a traumatic birth
- Knowledge of an abusive history (or current situation)

Treatments

- Gold standard:
  - Perinatal mental health care pathway with referral to tertiary services as needed
    - To include: perinatal psychology; adult mental health; eating disorders; and drug & alcohol misuse services
- Current reality:
  - Very patchy resources around the UK.
  - Very few specialist perinatal psychology services
  - Long waits, lack of onward referral

Warwick Hospital - Current Service

- Clinical input, inpatient/outpatient
- Perinatal mental health care pathway
- Maternity Services Liaison Committee
- Supervision
- Liaison between primary/secondary care
- National: guideline for antenatal and postnatal mental health (NICE)

Referral Guidelines

The primary problem is psychological:

- A definite / probable psychological difficulty following birth which would not exist if she had not given birth. e.g. postnatal depression/PTSD. She may be pregnant again.
- A physical problem or high risk pregnancy (e.g. pre-eclampsia, multiple birth) with emotional difficulty adjusting to the diagnosis (fear, anger, etc).
- A loss, with significant associated emotional difficulties
- A specific fear interfering with normal care e.g. needle phobia, extreme fear of childbirth (this may be related to a previous traumatic birth or not).

Referral pattern

Period	Number referred	yr on yr % change	% change from first yr
Oct 01-Sep 02	7		
Oct 02-Sep 03	31	+442%	
Oct 03-Sep 04	42	+35%	+600%
Oct 04–Sep 05	53	+26%	+757%
Oct 07-Sep 08	72	+36%	+929%

Clinical areas of involvement

- Antenatal mental health problems
- High-risk pregnancy
- Postnatal depression
- Previous puerperal psychosis
- PTSD: traumatic labour, postnatal course
- Phobias: labour, needles, hospitals, pregnancy, childbirth
- Loss: abortion, miscarriage, stillbirth
- Pain: perineal, abdominal, labour, breastfeeding
- Postnatal medical problems
- Interventions complicated by pregnancy (eg.chemotherapy)
- Denial of pregnancy
- Abuse history

Thank you!